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ZAMBIA AND NORWAY

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Students: Secunda Mwape Kalobwe Miyanda and Mukamba Caroline Wakunguma

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1.0 INTRODUCTUON

BACKGROUND

In the World Health Assembly Resolution of May 1995, World Health Organisation (WHO) made reproductive health as a priority area globally. Reproductive health is the ability of people to have a responsible satisfying safe sex life, the capability to reproduce and the freedom to decide when and how often to do so (WHO, 2014). The resolution urged its member states to further develop and strengthen their reproductive health programmes by strengthening the capacity of health workers in addressing the reproductive health needs of individuals in a culturally sensitive manner and specific to their age. This required improving the course content and methodologies for training health workers in reproductive health and human sexuality and to provide support and guidance to individuals, parents, teachers and other influential persons in these areas (WHO, 2011). At the same Assembly, adolescents were identified as the first and of the greatest concern population with a number of risks. A large proportion of the induced abortions, the increase in sexually transmitted infections (STIs) and the growing number of sex workers are in the adolescent group, putting them at a higher risk for the emerging epidemic of human immunodeficiency virus (HIV) (WHO, 2011).

WHO (2014) identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19 years. Adolescents are the largest population in the world today. One in five individuals in many countries is an adolescent, one in three and in some one in two (WHO, 2012). The period of adolescence prepares one for adulthood and it is a time at which several important developmental experiences occur. The onset of puberty marks the passage from childhood to adolescence but the duration and characteristics of this may differ across time, cultures, and socio economic situations (WHO, 2014).

Most adolescents face pressures to use alcohol, cigarettes, or other drugs and engage in sexual relationships at earlier ages, putting themselves at high risk for injuries, unplanned pregnancies, and infection from STIs including HIV. This behaviour patterns can have long lasting positive and negative effects on their future health and well being (WHO, 2014).

Generally, adolescents are not fully competent to understand complex concepts making them vulnerable to sexual exploitation and high risk behaviours. These concepts include, the relationship between sexual behaviour and its outcomes, the degree of control they have or can have over health decision making including that related to sexual behaviour. Laws, customs, and practices may also affect adolescents differently than adults (WHO, 2014).

Parents, members of the community, health service providers, and educational institutions have the responsibility to provide guidance and counselling to adolescents in order to help them cope with the pressures they face and make the transition from childhood to adulthood successfully. Adults therefore, have unique opportunities to positively influence young people so as to promote development and adjustments and make them be able to intervene effectively when problems arise (WHO, 2014).

In Zambia, adolescents account for over a quarter (27%) of the total population. In 2000, the Zambian Government introduced Youth Friendly Health services which promoted Family life education widely as it was realised that, adolescents are a special group and require special attention (Ministry of Health, 2009).

Additionally in 2011, a national Adolescent Health Strategic Plan 2011 to 2015 (ADH-SP 2011-15) was developed. It outlined the strategic framework that would promote the delivery of appropriate, comprehensive, accessible, efficient and effective Adolescent Friendly Health Services (ADFHS) throughout the country, so that adolescent health problems are comprehensively addressed (Government Republic of Zambia, 2011). Furthermore, the Government Republic of Zambia (2012), recognised the importance of investing in the education sector through the provision of comprehensive sexuality education and reproductive health information. This is largely so because it increases the potential and opportunity of reaching out to young people as a large population of adolescents are in school.

Norway teaches a comprehensive sex education which is compulsory and the curriculum is mandated for all schools. The national sex education curriculum stresses individual choice, contraception and intimacy. The aim of sex education in Norwegian schools is to give the pupils a basis on which they can form their own opinions about how to live and how to assess what is right or wrong for them in this area (Barz, 2007).

STATEMENT OF THE PROBLEM

Today's adolescents will determine the social, economic productivity, as well as the reproductive health including the well being of nations in the world and in the decades to come. There are more than one billion adolescents of which 70% live in developing nations (Hindin and Fatusi, 2009). Due to greater access to formal education, increased technology, different job opportunities, and more exposure to new ideas, adolescents are growing up in circumstances quite different from those of their parents making parent-child communication difficult. The environment in which young people are making decisions related to sexual and reproductive health is also rapidly evolving (Hindin and Fatusi, 2009).

About 16 million girls aged 15 to 19 years give birth every year, accounting for about 11% of all births worldwide (UNFPA, 2012). In sub-Sahara African region, there is a continued rapid population growth, high birth rates, and escalating rates of HIV infection. Unprotected adolescent sexual activity significantly contributes to these numbers (Advocates for youths, 2008). 15% of all unsafe abortions in low and middle income countries are among adolescent girls aged 15 to 19 years (UNFPA, 2012).

Zambia carried out a situation analysis in 2000 on reproductive health services for adolescents and young people in the country which identified the gaps, such as high teenage pregnancies, inadequate access to Reproductive Health Services and information (Sipangule, 2011). According to the Zambia Demographic and Health Survey 2007 (ZDHS), approximately 7% of female adolescents and 4% of male adolescents are HIV positive, and 3 in 10 female adolescents have either given birth or carrying a pregnancy. The pregnancy rate among teenagers is 146 per 1,000, and is higher in rural areas than in urban ones. 28% of adolescents have already had a child, and the median age at first marriage for women is 18 years (UN, 2010). Unmet need for contraception is high (22 %) among married female adolescents and even higher (64 %) among sexually active adolescents who are not married (Taylor, 2013). There is a reluctance to provide information about contraception to unmarried girls due to cultural and religious beliefs and expectations. There is inadequate Sexual and Reproductive Health (SRH) information available in schools and in the community and young women are not empowered to make informed decisions about their SRH (Taylor, 2013).

According to the Southern and Eastern Africa Consortium of Monitoring Education Quality, 65% of grade six pupils in Zambia lacked basic information on HIV. Additionally, the 2010 Educational Statistical Bulletin revealed that over 15,000 female learners dropped out of school in 2009 because of unplanned pregnancies. This indicates how much more needs to be done to address the challenges and protect adolescents from risks of HIV infection, other STIs and unwanted pregnancies (UNFPA, 2012).

Norway's culture accepts premarital sex and according to the Innocenti Report Cards, 80% of Norwegian adolescents practised sex whilst in their teens (UNICEF, 2001). In 2012 Norway recorded 15 216 induced abortions, of which 11.4% were done on adolescents aged between 11 and 19 years (Norwegian Institute of Public Health, 2014). This shows that Norway is also facing challenges with adolescents sex and reproductive health such as unprotected sex resulting in unwanted pregnancies, greater risk of contracting STIs and HIV.

PURPOSE OF THE STUDY

- ◆ To compare source of information on sex education for adolescents in Zambia and Norway.
- ◆ To explore the role of parents, teachers and nurses in adolescents sexual
- ◆ education in Zambia and Norway.
- ◆ To understand how information about adolescents sexual and reproductive health is given in different cultures.

2.0 LITERATURE REVIEW

According to Polit and Beck (2014), literature review is a well written synthesis of information about a topic that includes a discussion on the research that has been done and the evidence gathered, the methodologies, the strength and weaknesses of findings and the gaps that require more knowledge.

Definition of concepts

WHO's constitution defines **health** as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”(WHO, 2013). Within the framework of this definition, reproductive health or sexual health addresses the reproductive processes, functions and system at all stages of life. It means that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2014).

Sexuality is a central aspect of being human throughout life which includes sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. Sexuality is also influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (WHO, 2006).

Sexual health according to WHO, “is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love. Fundamental to this concept are the right to sexual information and the right to pleasure” (Knowles, 2012).

Sex education is the information on issues relating to human sexuality, including sexual anatomy, sexual reproduction, sexual activity, reproductive health, emotional relations, reproductive rights and responsibilities, abstinence and birth control. Major players for sex education are parents or adults, formal school programs, and public health campaigns (WHO, 2013).

Health services are those services provided by a health worker to an individual aimed at preventing a health problem, or detecting and treating one. It includes the provision of

information, advice and counselling (WHO, 2012).

History of sex education

In order to understand and appreciate adolescents sex education in Norway and Zambia, it is important to review the history of adolescents sex education. However, it is difficult to find information specifically for Zambia and Norway. Therefore, information from other countries has been included.

Prior to the twentieth century, sex education was haphazard. Most Americans and Europeans lived in the countryside, where opportunity observation of animal behaviour provided young people with some information about reproductive sexuality. Beyond that, education was mixed. Girls were expected to remain virgins until their wedding night. Sex education did not seem urgent until the eve of matrimony, when their mothers were expected to sit them down and explain sex and reproduction. On the other hand, boys often were taken to a brothel to be introduced into the mysteries of sex by his male relatives or co-workers (Encyclopedia, 2008).

The formal movement for sex education started in the early twentieth century. In societies experiencing rapid urbanization, such as China at the dawn of the twenty first century, newspapers regularly reported on young city couples who wanted children for years but never picked up the essential information on animal breeding that would have suggested how to become pregnant. American reformers, like their counterparts in England at around the same time, were more focused on the related dangers of medical and moral decline. Physicians were alarmed about the increasing impact of syphilis and gonorrhoea which are STIs and they associated this "epidemic" with what many Americans considered the immorality of life in the city (Encyclopedia, 2008).

In the mid 20th century, most of the information on sexual matters was acquired informally from friends and the media. Much of this information was inadequate or of questionable value, especially during the period following puberty when curiosity of sexual matters is so intense. This inadequacy became increasingly apparent by the high incidence of teenage pregnancies, especially in Western countries after the 1960s. As part of each country's efforts to reduce such pregnancies, programs of sex education were established (encyclopedia , 2014).

By 1988, more than 90 percent of all United States schools offered some sex education programs. Public sex education emerged at precisely a moment when conceptions of a childhood sexually were transforming. This change in cultural perceptions, along with rapidly increasing sexually transmitted infection largely attributed to the morally desolate conditions of urban life and prompted individuals reforms to claim a leading role in the moderation of these realities. Education became the means by which public authorities and the elite institutions communicated particular information dedicated to accommodating the current tension between modern scientific methods, traditional moral norms and values (Vicuna and Mar, 2013).

Different motivations for comprehensive sexuality education have gradually made their way into policies and programs, which differ between countries. For instance, in the United States, the concentration on keeping young people safe has been interpreted into prevention oriented programs. Although these programs may cover a wide range of topics from fertility and reproduction to STIs, from relationships and communication to gender norms, culture and society they are primarily aimed at helping adolescents minimize their risk of adverse outcomes. Northern European countries like Sweden and the Netherlands, embrace a positive attitude toward adolescent sexuality, based on the premise that young people are "rights-holders," hence, are entitled to information and education, as well as the right to express and enjoy their sexuality. These rights based or "holistic" programs are concerned with educating young people to avoid unplanned pregnancy and STIs. They are focused less on behaviour and outcomes. Instead, they are more concerned on reflection and choice. The underlying assumption is that empowering young people to make considered, informed decisions about their own lives and helping them to develop the critical thinking skills and sense of self necessary to do so will result in better sexual and reproductive health in the widest sense including pleasure, love and sexual well being (Boonstra, 2011).

In 1995, WHO, in conjunction with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), came up with a common agenda for action in adolescent health and development. Objectives for this agenda included the promotion of healthy development in adolescents, prevention of and response to health problems if and when they arise. It involves implementation of a collection of interventions, designed to meet the special needs and problems of adolescents, which

includes the provision of information and skills, creation of a safe and supportive environment, and the provision of health and counselling services (WHO, 2013).

WHO developed sexual and reproductive health (SRH) strategies for Europe in 2001 and globally in 2004. These strategies were based on the Cairo agenda, for accelerating the trajectory toward health by strengthening health systems capacities, improving information for priority setting, mobilising political will, creating supportive legislative and regulatory frameworks, and strengthening monitoring, evaluation, and accountability systems. Adoption of sexual and reproductive health as key to the sustainable development of societies necessitated the creation of new reproductive health programmes and policies. Countries can use these strategies as guidance in developing and reforming their reproductive health services in the health system (WHO, 2012).

Sex education in Norway has been taught in biology classes since 1939 and was made a compulsory part of biology in 1950. The modern sex education system originated in 1971 when the subject of ‘human reproduction’ was diversified to a comprehensive curriculum which encompasses sexual desire, masturbation, homosexuality, contraception, family planning, abortion and STIs (Bartz, 2007).

In 1995, Zambia government got assistance and funding from the Swedish International Development Authority (SIDA) to develop Adolescent Reproductive Health Project. Central Board of Health (CBOH) chose Kafue District since it included both urban and rural settings which lacked sexual and reproductive health programmes. The area was also a high risky for HIV/AIDS and other sexual transmitted infections (STIs) as it was situated along the high way to Zimbabwe and South Africa. In April 2002, the program was integrated into the district offices of the Ministry of Education, Ministry of Community and Social development (Valerio and Bundy 2004).

Source of information

From the moment babies are born, they are learning about different prospects of sexuality; their bodies, gender, touch and affection. This learning continues throughout their life and the messages bestowed to children about sexuality often have imperishable impact. Parents, caregivers, and families play a cardinal role in this process. It is essential that communication between parent and a child is both open and positive and

that it start as early as possible (SIECUS, 1996).

Parents teach their children many things about sexuality and have been since the day the children were born. Children learn from the way they are physically touched and caressed by others, the way their care takers' bodies feel to them, what their family accepts is okay and not okay to do. Additionally, children learn from the words that family members use and do not use to refer to parts of the body, watching the relationships around them, and observing male/female roles. They also pick up a great deal from outside the family every time they watch television, listen to music, and talk with their friends (Alberta Health Services, 2014).

The era in which adolescents grow up nowadays is very different from that of their parents or grandparents. Adolescent today have more opportunities and challenges compared with the youth of past generations. They have more independence from their parents and are likely to spend more time in school. They have more access to the radio, television, Internet and mobile phones (Boonstra, 2011).

According to the research which was done in southern California, Ladapo, et al (2013) indicates that, increasing parental involvement in the sexual health education of their children can delay intercourse, increase use of contraception, reduce risk-taking behaviour, and decrease sexually-transmitted infections (STIs). Nevertheless, many parents do not talk to their children about sexual matters. Parents often mention feeling poorly informed, embarrassed, or unsure of what to say or how to begin.

Research done in United States in 1995 on parent and peer communication effects on AIDS related behaviour among United States high school students, found that adolescents communication with parents or with peers greatly affect risk behaviour, but in opposite ways. Discussions about HIV with parents tend to reduce the likelihood that adolescents will engage in risky behaviour, while communication with peers increases that likelihood. The analysis by gender suggest that male adolescents are more influenced by discussions with peers, while female adolescents are more affected by communications with parents (Holtman and Robinson, 2014).

Parents and other family members have always played a critical role in the physical, emotional and sexual development of young people. It is important to note that, in today's world, these sources of education are insufficient and that more organized,

formal approaches be established. Comprehensive sexuality education for adolescents is not available in many regions of the world and where it exists, adolescents' knowledge of sexual and reproductive health is not detailed. There are still many myths associated with reproductive health, such as one cannot get pregnant the first time she has sexual intercourse or if she has sex standing up (Holtman and Robinson, 2014).

Health workers are among the people who contribute to the health and development of adolescents. They have important contributions to make in helping healthy adolescents stay well, and in helping ill adolescents get back to good health. They do this through provision of information, advice, counselling and clinical services aimed at promoting health and preventing health problems and problem behaviours (WHO, 2012).

All adolescents need access to quality youth-friendly services provided by clinicians trained to work with them. Sex education programmes should offer accurate, comprehensive information while at the same time building skills for negotiating sexual behaviours. Girls and boys also need equal access to youth development programmes that connect them with supportive adults and with educational and economic opportunities (Bearinger, et al., 2007).

In Zambia, since 1996, a number of Youth Friendly Corners (YFCs) have been established, which are intended to provide youth friendly health services. These services are targeted at youths, which is a much broader target group, representing different age groups with varying health needs. Currently, there are no health care services specifically targeting the adolescents and their special needs leaving them with only two options, either to access health services through the YFCs, where they exist, or accessing the standard health services offered to the general public (Government Republic of Zambia, 2011).

Education and literacy are important tools for understanding and explanation of information on adolescent health and for accessing better jobs and household wealth status by adolescents and their families (WHO, 2006).

Norway fosters a liberal social and moral climate and was one of the first countries to pass a law criminalizing discrimination on sexual grounds. Sexuality education has been compulsory in Norway since the 1970s and the government has set minimum regulations for its provision. The aim of sex education in Norwegian schools is to give the pupils a foundation on which they can form their own views about how to live and

evaluate what is right or wrong for them in this area (Bartz, 2007). Sexuality education is

mainly integrated into the curriculum of biology lessons. School teachers are responsible for its provision in collaboration with school nurses who deal with topics deemed to be more 'difficult' (Lazarus, et al., 2009). It advances in a systematic and age appropriate manner. Students learn about family, society's rules, norms and gender roles in early elementary school. In later elementary school, they enter fact-based discussions of the body and puberty as well as more emotional topics such as relationships, conflicts and sexual identity (Bartz, 2007). In high schools, contraception, AIDS, STIs, homosexuality, masturbation and abortion are taught and earlier topics are revisited in more detail (Bartz, 2007). Teaching methods differ and some teachers split classes according to gender (Lazarus, et al., 2009). The Ministry of Education in Zambia has been working with other stakeholders to operationalize the process of integrating comprehensive sexuality education curricula for the young people who are in and out of school. It is a collaborative effort of the United Nations System and the Ministry of Education as a strategic step to strengthen sexuality education in Zambia's Education Curriculum (Government Republic of Zambia, 2011).

Benefits of sex education

Comprehensive sexuality education is one of the most important tools to ensure that young people have the information they need to make healthy and informed choices. This requires considering the various interrelated dynamics that influence sexual choices and the resulting emotional, mental, physical and social impacts on each person's development. Adolescents sometimes do not have access to neither accurate information on the issues related to sexuality and sexual health, nor solutions for their problems due to socio-cultural barriers. They often get information about sexuality from friends and through the print and electronic media which is often wrong and unscientific (Prabhu, 2014).

Advocates for Youth (2009), reports that young people need honest and effective sex education. Comparative research in the United States showed that comprehensive sex education programs do not encourage teens to start having sexual intercourse, do not

increase the frequency with which teens have intercourse, and do not increase the number of adolescents sexual partners. On the other hand, evaluations of publicly funded abstinence-only programs have continually shown no positive changes in sexual behaviours over time. Many women's organizations feel that the girls should not be ignorant about basic concepts

of life and turn into victims of sexual abuse, unwanted pregnancy and deception. In a study of AIDS prevention programme done by UNICEF of selected Municipal Schools in Bombay (Mumbai), it was found that students asked questions ranging from sexual intercourse to marriage and sexual harassment. Additionally, studies on the effects of sex education in schools show that sex and AIDS education often encourages young people to delay sexual activity and to practise safer sex, once they are active (Prabhu, 2014).

Some international organizations such as Planned Parenthood consider that broad sex education programs have global benefits, such as controlling the risk of overpopulation and the advancement of women's rights. Additionally, the outbreak of AIDS has given a new sense of urgency to sex education. In many African countries, where AIDS is at epidemic levels, sex education is seen by most scientists as a vital public health strategy (UNFP, 2012).

A study has demonstrated that comprehensive sexuality education programs are potentially cost effective as well. In 2010, UNESCO commissioned a study of the health impact and cost effectiveness of school based sexuality education in Estonia where sexuality education is included as an element of compulsory human studies courses for grades 5 to 7 and it is strongly linked to youth friendly sexual health services in the community. According to the study, between 2001 and 2009, after the introduction of sexuality education in Estonia, there were significant improvements in adolescent sexual and reproductive health. Nearly 4,300 unintended pregnancies, 7,200 STIs and 2,000 HIV infections among adolescents aged 15 to 19 were avoided. If even 4% of the reduction in HIV infections were attributed to sexuality education, the researchers estimate that the program would result in a net savings (UNESCO, 2011).

Motivation

Most parents would like to play a role within their children's sexual health education. Some parents motivation to do so come from a desire to provide knowledge to their children which they had received from their own parents. Most of the parents feel they should be talking with their children as a way of protecting them from negative sexual health consequences, such as STIs and unplanned pregnancies (Alberta Health Services, 2014).

Culture

Culture can be defined as "the attitudes and behaviour that are characteristic of a particular social group or organization"(Advocates for Youths, 2008). It provides the structure for people's social activities, contributes to their belief of community, and helps individuals form their identity. It is an essential component of the foundation of every society.

In Zambian culture, issues of sex are considered entirely private, very sacred and should not be talked about in the open and just with any audience. They have a place and time when they are discussed in the life of a girl or boy. For example, as a girl starts to experience physiological body changes, she is encouraged to keep a distance from people of the opposite sex irrespective of the relationship to her including her own father. This is to avoid unintentional arousing men sexually. The first thing a young girl is taught is to avoid sexual attraction to herself which could lead to unintended consequences, with disastrous results and useful taboos being broken (Tembo, 2012).

Since Zambia is the “we” type of society (ubuntu), one needs other people to be empowered and get energy to be a good human being (Shutte, 2004). It is not just primarily the duty of the parents to teach their children on matters of life including sex education, but also grandparents, aunties, uncles and other adults play a major role. Its a responsibility of the whole community in which a child lives to ensure that the child preserves values and norms (Tembo, 2012).

This Zambian culture is to some extent dying due to globalisation. Globalisation is the process of international integration due to the interchange of world views, products, ideas, and other forms of culture. Some critics argue that globalization harms the

diversity of cultures leading to Westernization or Americanization of culture, where the dominating cultural concepts of economically and politically powerful Western countries spread and cause harm on local cultures (Wikipedia 2014).

Since Norway embraces an Egalitarian philosophy, it believes in equality for all its people and where everyone is treated and respected the same. Norway acknowledges the need for clear communication and comprehension of minority cultures so that everyone can make informed sexual decisions and be able to filter through the competing media and societal images to which they are exposed (Bartz, 2007). According to Bartz (2007), states that Norway attitudes to sex are now mostly based on the principle that adolescent and young

adults of both sexes are entitled to have sex at the age of 16.

Challenges

Parents want to provide the guidance and knowledge their children need to become responsible and happy adults. However, they are sometimes afraid of talking about sexuality with their children because they are uncomfortable talking about reproductive body parts and functions. They also wonder if talking about sexuality and reproduction

will encourage their children to experiment and for many parents, the topic of sex never came up when they were growing up as a result, they are not sure what their children need to know and at what age they need to know it (Alberta Health Services, 2014).

Culture sometimes can limit adolescent's access to the information and services they need to make informed and responsible decisions about their sexual and reproductive lives. For example, according to the Zambian tradition and culture, it is a taboo to discuss sexual matters with somebody from the opposite sex, unless between grandparents and grandchildren. Additionally, it is a taboo to discuss sexual matters with one's own child (Mburu, et al. 2014).

3.0 RESEARCH DESIGN AND METHODOLOGY

Research design is the plan, structure and strategy of investigations of answering the research questions (Basavanthappa, 2007). It is the overall plan or blue print the researchers select to answer the questions being studied.

Research methodology is a technique used to structure a study and to gather and analyse information in a systematic fashion (Polit and Beck, 2010). It outlines the research design, study population, sample selection, data collection tool and techniques to be used in the study, pilot study and ethical considerations.

In this study, the researchers used a qualitative method that is exploratory, descriptive and contextual in order to gain a rich understanding of the phenomenon as it exists in the natural setting. Qualitative research describes research that is focused primarily on human experience through exploring attitudes, beliefs, values and experiences (Whitehead, 2007).

Data collection method

Data collection tool/method may take the form of a questionnaire or interview schedule, check list, projected device or some other type of tool for eliciting information (Polit and Beck, 2006).

In this study, data was collected using a semi structured interview guide. A semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable and comparable qualitative data (Legard et al 2003). It contains structured, unstructured and open-ended questions. The interviewer and respondents engaged in a formal interview and participants were encouraged to talk freely about all the topics on the list and to tell stories in their own words in order to provide as much detail as they wish and offer illustrations and explanations. Care was taken not to ask closed-ended questions. The goal was to ask questions that give respondents an opportunity to provide rich detailed information about the phenomenon under study (Polit & Beck, 2008, pp. 394).

Advantages of using Semi-structured interview schedule

1The interviewer can prepare the questions in advance and appear competent during the interview.

2It allow informants the freedom to express their views in their own terms.

3It provides reliable, comparable qualitative data (Cohen, 2006).

Disadvantages

- 1 It is difficult for the interviewer to interview, record and listen at the same time.
- 2 Interviews take time to be complete and even longer to transcribe into a written record of what was said (Walsh & Wigans, 2003, pp. 93).

Population

Population in research is a collective term used to describe the total quantity of cases of the type which are the subject of the study. It can consist of objects, people, or even events e.g. schools, miners etc., (Walliman, 2005, pp. 274).

In this study, our study population comprised of parents, teachers and nurses from both Norway and Zambia.

Sample selection

A sample is a subset of a population selected to participate in a study (Polit and Beck, 2010). Sampling is a process used to select a portion of the population for study. Qualitative research is generally based on non probability and purposive sampling (Ploeg, 1999). Purposive sampling was used in this study where samples were selected in a deliberate manner. The goal or purpose for selecting the specific study units is to have the one that will yield the most relevant and plentiful data of the study (Yin, 2011).

Samples consisted of parents, teachers and nurses from both Norway and Zambia.

Data collection techniques

Data collection technique is the actual method of how the data will be collected (Polit and Beck, 2006). The researchers conducted the interviews in a conducive and private place, comfortable for the researchers and the respondents. One of the researchers was conducting the interview using structured interview guide while the other was taking notes with the consent of the respondents. Raw data was read through thoroughly to

obtain the meaning in full. Data was then analysed using content analysis, which is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts (Polit and Beck, 2010). The 2 researchers carried out the content analysis individually after which they met to compare and discuss the information given in this document.

ETHICAL CONSIDERATIONS

Ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit and Beck, 2010).

They include principles of autonomy or self determination (respect) for persons, beneficence, non-maleficence and justice that are relevant to the conduct of research (Flick, 2011). The respondents have the right to know the purpose of the research, the nature of the study situation and the results of the study. Researchers obtained written permission from the relevant authorities like the University authorities through the supervisor before starting the project. The study was approved by the head nurse at the health centre before data collection (refer to Appendix 1 and 2). A written consent form was formulated and approved by the supervisor which contained the nature of the study and all legal obligations such as the right to withdraw from the study among others (refer Appendix 3). During the study, the nature of the study was explained to the participants and confidentiality was assured. The researchers introduced themselves to the respondents after which the respondents were asked to sign a consent form which gave the researchers permission to conduct the interview. The completed semi structured interview guide (refer Appendix 4) was kept under strict security conditions to avoid unauthorized access to the information. Any literature used in the research was cited correctly to give recognition to the author because plagiarism is not allowed.

PILOT STUDY

A pilot study is a smaller version of a proposed study conducted to develop and refine the methodology such as treatment, instruments, or data collection process to be used in a larger study (Burns and Grove, 2005). The pilot study helped the researchers determine the feasibility of the study and reliability of the data collecting tool. The pilot study was conducted on one Norwegian nurse and one Zambian parent. All steps that were expected to take place in the main study were followed. The pilot study helped the researchers identify and make necessary changes to the interview guide. For example question number four (4) which read “What challenges do you face when talking to adolescents on issues concerning sex and reproductive health?”. The word 'adolescents' was replaced with 'children' as this

question was directed to parents (refer to Appendix 1). It also helped the researchers estimate how long an interview would take. In this study, each interview took approximately 25 minutes. Furthermore, it gave the researchers an experience of how they would conduct themselves during the interviews.

We considered data collected from the pilot study into the final study.

4.0 DATA ANALYSIS

Qualitative analysis is the organization and interpretation of narrative data for the purpose of discovering important underlying themes, categories and patterns of relationships (Polit & Beck, 2012). The purpose of data analysis is to organize, provide structure to and elicit meaning from data (Polit & Beck, 2012). In this study, qualitative data was collected using an interview guide in which the notes were taken in the field. Data was analysed using content analysis, which is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts (Polit and Beck, 2010).

RESULTS OF FINDINGS

Seven (7) informants were interviewed. Two (2) of the informants were Norwegian nurses/midwives. Four (4) of the informants were parents, three (3) were Zambian and one (1) Norwegian. Two of the informants were teachers, one (1) Norwegian and one Zambian.

The 2 researchers agreed on the content of the data and identified the following themes;

Source of information

Source of information was similar to both Zambia and Norway. When asked about the source of information concerning sex education, both Norwegian and Zambian parents interviewed confirmed being the primary source of information to their children. Most of the parents start as early as 3 years of age talking to their children about sex and reproductive health. This information is supported by a statement from one of the Zambian parents who said; *“I tell my 3 year old daughter not to allow anyone to touch her private parts”*.

One of the Norwegian parent also said ; *“a child just like any other person has the right to know the truth. So if the child asks a question no matter how sensitive it might be, he/she has to be answered truthfully”*. She cited an example when her child asked her as to why she looks like her father yet she was in the mother's tummy. The mother explained to the child;

“Your dad had to put his penis into mum's vagina and released an egg which fused with mum's egg and you were made”.

School is another source of information on sex education and reproductive health in both Zambia and Norway. All the teachers who were interviewed confirmed having information on reproductive system in the curriculum from the fifth grade when children are about 10 years of age. This education continues up to high school. This is in line with what one of the teachers said; *“they start learning about their bodies in the fifth grade when they are about 10 years old then about sexuality when they are 14 years old”.*

Health care providers are another source of information. In our research, it was revealed that in both Norway and Zambia, schools and health workers work in collaboration. In Norway, it is a responsibility of the health centre in the area to provide sex and reproductive health services to school children which include information on how the body develops, STIs, contraception and how to respect each other in a relationship among others. This is supported by the what the Norwegian nurse said; *“at 10-11 years when children are in fifth grade, they have education on puberty and reproduction in schools and I go in class after the teacher has taught. They are taught about, how babies are made, puberty and how the body develops that is, from child to youth and then to adulthood”.*

In Zambia, most health care centres run youth friendly corners where youths access reproductive health care services. Nurses also visit schools every year and when they are called upon by the school management to go and offer reproductive health care services. This is supported by the Zambian teacher who said; *“Once in a year, nurses come to talk to pupils on STIs, cervical cancer and the school is in collaboration with the clinic in the area and they are called upon any time if there is need”.*

Motivation

Most of the Zambian parents revealed that, happenings in the area and reports on television and other media about cases such as defilements motivates them to start talking about sex and reproductive health. One of the Zambian parents said; *“I wait for incidences such as reports of defilement and sexual harassment on television”.*

Another Zambian parent said; *“My husband and I started talking to our son when there was a case of sodomy which happened to our nephew”.*

Contrary to Norwegian parents where such cases of defilement are not so much happening,

they are motivated by the questions that children ask. This is supported by what one of the Norwegian parent said; *“I wait until they start asking questions”*.

Challenges

All the parents from both Norway and Zambia had challenges in communicating with their children. One of the Norwegian parent said; *“I have a challenge within myself because it is difficult to talk to my own kids because they are so close to me but its easier talking to other kids on the same matter”*.

Another parent from Zambia stated language as a challenge; *“certain terms like sexual intercourse are difficult to mention in vernacular, so instead I will simply say sleeping with a boy or girl”*.

Professionals too faced some challenges in communicating with adolescents on sexual and reproductive health issues. Teachers from both Zambia and Norway faced the same internet challenge. This is supported by the statement from one of them; *“adolescents think they know everything because of what they read and watch from the internet”*.

A Norwegian teacher added; *“attitude of both teachers and students is also a challenge because it is not as natural as maths”*. The Zambian teacher cited another challenge of

inadequate teaching aids in the department; *“we have no videos for the department, we only use posters for discussions”*.

Nurses also had a similar challenge of the internet as one said; *“too much information from the internet, they think they know it all and others get scared. They think sexuality is all about intercourse and yet they lack respect, communication and knowledge”*. Another Norwegian nurse said; *“sometimes they think they get better information from friends and that I am too old”*.

Openness

Some parents felt free talking to their children of the same sex. This is supported by the statement from one male parent who said; *“am free talking to my son than my daughters”*.

On the other hand, other parents felt more free talking to their children of the opposite sex like one mother said; *“am more free discussing sex issues with my son than my daughter, may be because he has asked more questions. I only feel free discussing with my daughter issues like menstruation because its real/natural.”*

Community programmes

Informants from both Norway and Zambia mentioned having programmes on sexual and reproductive health for adolescents in their respective communities. This statement is supported by a Norwegian parent who said; *“we have members from Red cross organisation who work with student nurses from Forde in educating students in schools on sex and reproductive health issues”*.

Additionally, one Zambian parent said; *“there is a drama group of women known as Nakatendo which goes round in the communities educating people on issues such as consequences of early marriages and unprotected sex”*.

All teachers confirmed having sexual and reproductive health education incorporated in the school curriculum. This is supported by one Norwegian teacher who said; *“we start teaching pupils about their bodies in their fifth grade and sexuality at 14 years”*.

Zambian teacher also said; *“we start teaching the pupils on reproductive health when they are in grade 5 and it is included in the school curriculum”*.

Nurses also confirmed offering the same programmes to pupils when they are in 5th and

10th grade. This information is supported by statement from one of the nurses who said;

“we run a clinic and we have an office in the school which is open 3 hours a week for the 16 to 20 year old for family planning and chlamydia screening”.

5.0 DISCUSSION OF FINDINGS

Source of information on sexual and reproductive health issues.

Adolescents of this generation have several sources of sexual and reproductive health information some of which are not effective while others are good. According to Boonstra (2011), the era in which adolescents grow up nowadays is very contrary from that of their parents or grandparents. They have more access to the radio, television, Internet and mobile phones. It is essential that people who are influential in the development of adolescents be fully involved in sex education.

Parents and other members of the family are the first people the baby comes in contact with in life and learning about sexuality starts from birth. It is therefore, important for parents to discuss sex and reproductive health issues with their children because they are the primary source of learning. As SIECUS (1996) states, from the moment babies are born, they are learning about different prospects of sexuality; their bodies, gender, touch and affection. Parents, caregivers, and families play a cardinal role in this process. Findings of our study revealed that all parents from both Norway and Zambia talk to their children about sex issues as early as the age of 3 years although the content of information given was different.

Our study revealed that in Norway, children are given full information especially when he/she asks because they believe children have a right to know the truth as Advocates for Youth (2009), reports that young people need honest and effective sex education. For example, if a child asks where babies come from, parents will tell the child that dad put his penis into mum's vagina and left a sperm inside which met with mum's egg and a baby is formed. On the contrary, in Zambia, the information given to the child at this age is usually about how to be responsible with his/her own body that no one should touch his/her private parts. If the child happens to ask about how babies are formed, parents usually will say babies are from God then they are put in mum's stomach or that

they are bought from the supermarket. According to Baylies (2002), in Zambian culture, it is a taboo to discuss sexual matters with one's own child .

Schools are another source of information on sex and reproductive health. Our study revealed that, school curricula for both Zambia and Norway were similar. It further revealed that, sex-education starts from 5th grade where adolescents are taught about their bodies, reproductive system and puberty. Then from the age of 14 years, they start learning detailed

sexual education which include family planning, STIs, HIV and values in a relationship. In Zambia, each school has guidance and counselling department headed by a trained teacher. This office is open throughout working hours so that children with different problems like pregnancy, STIs or social issues can seek help from there.

It was also discovered in our study that health professionals also play a major role in giving sex education to adolescents. This is in line with WHO (2012), which states that, Health workers are among the people who contribute to the health and development of adolescents. They have important contributions to make in helping healthy adolescents stay well, and in helping ill adolescents get back to good health. They do this through provision of information, advice, counselling and clinical services aimed at promoting health and preventing health problems and problem behaviours.

The study revealed that although nurses from both Norway and Zambia are adolescents sex educators, the way information is given is different. In Norway, the school health program is well organised with each school having a school nurse with an office within the school premises. This school nurse offers guidance and counselling on different health issues such as family planning to those who are 16 years and above, screening for chlamydia among and counselling others. They even have a website where adolescents send anonymous questions to health professionals. Additionally, it is a responsibility of the health centre in the community to plan for the school health programmes contrary to Zambian way where the teacher in charge of guidance and counselling plans and then invites the nurse from the nearest health centre to visit the school. Despite this difference, there was still some similarities of nurses visiting schools at least once a year to go and talk to adolescents.

From the 2 researcher's perspective, despite the way of disseminating information being different, parents, teachers and health professionals are major players in giving

sexual and health education to adolescents.

Benefits

Our study revealed that, benefits of sex education were similar in both Zambia and Norway. This includes being able to decide what to do to their own bodies, knowing what is going on in their bodies as part of their bodies developments, consequences of sex, how to behave in a relationship, how to protect themselves against STIs, HIV and unwanted pregnancies. This is

similar to the results of the evaluations of comprehensive sex education programs done by Advocates for Youths (2009), which showed that these programs can help youth delay onset of sexual activity, reduce the frequency of sexual activity, reduce number of sexual partners, and increase condom and contraceptive use.

Motivation

Our study revealed that parents from both Zambia and Norway got motivated in talking to their adolescents differently. One parent from Zambia sited knowledge in science as his motivation that as a child is growing, he/she undergoes developmental changes such as puberty and feelings towards sex which is normal. The other Zambian parents said they are motivated by incidences that occur in their communities or reported on television and other forms of media such as rape, defilement and sodomy. The Norwegian parent mentioned that, she gets motivated by the questions children ask especially after they learn about sex education from school. This is in line with what is indicated by Alberta Health Services (2014), that, some parents motivation to talk to their children come from a desire to provide knowledge to their children which they had received from their own parents.

Challenges

Our study revealed that almost all the respondents faced a challenge in talking to adolescents on sexual and reproductive health issues due to increased technology as Boonstra (2011), indicated that, they have more access to the radio, television, Internet and mobile phones. They get a lot of information from these other sources some of

which is wrong and inadequate. Furthermore, adolescents often get information about sexuality from friends and through the print and electronic media which is often wrong and unscientific. This makes them think as if they know everything and they do not pay attention to what their parents, teachers or nurses teach them (Prabhu, 2014).

Some parents from both Zambia and Norway said they feel shy to talk about sex and reproductive health issues with their children since traditionally parents are not suppose to talk to their children but instead its the aunties, grandparents and uncles who are responsible for that. One of the Zambian parent also cited facing a challenge to mention some words such as sexual intercourse, penis and vagina especially in vernacular. According to Alberta

Health Services (2014), parents are sometimes afraid of talking about sexuality with their children because they are uncomfortable talking about reproductive body parts and functions.

Openness

The study revealed that some parents were free discussing sexual and reproductive health issues with children of the opposite sex while others were more free with children of the same sex. The study revealed that female parents from both Zambia and Norway were more free talking to the children of the opposite sex while the male Zambian parent felt more comfortable talking to the children of the same sex. As Baylies (2002), indicates, it is a taboo to discuss sexual matters with somebody from the opposite sex in the Zambian tradition and culture.

School curriculum

Our study revealed that the school curriculum for both Zambia and Norway is similar in that they start teaching the children sex and reproductive health in the fifth grade when children are about 10 years old. They teach them about how babies are formed, their bodies and puberty. From about 14 years of age, detailed information on sexual issues is given in schools such as STIs, contraception, and how to go about in a relationship. Adolescents are taught separately according to gender and sometimes they are taught together. This makes them feel free to discuss and ask questions on certain issues such as menstruation for girls. According to Lazarus, et al. (2009), sexuality education is

mainly integrated into the curriculum of biology lessons. School teachers are responsible for its provision in collaboration with school nurses who deal with topics deemed to be more 'difficult'. Teaching methods differ and some teachers split classes according to gender.

Community programmes

Our study revealed that both Zambia and Norway have community programmes which also teaches adolescents sexual and reproductive health matters. The researchers found that,

adolescents get information on sex and reproductive health issues not only from the parents, teachers and nurses but from the community as well. As Alberta Health Services (2014), indicated, adolescents also pick up a great deal from outside the family every time they watch television, listen to music, and talk with their friends. This means that disseminating information in form of drama as a case in some parts of Zambia is beneficial.

6.0 STRENGTHS AND WEAKNESSES OF THE STUDY

The data collection method used (qualitative) is one of the strengths of the study in that, it enabled the researchers to collect detailed information from the informants about the topic under study. All informants were willing to participate in the study. The researchers shared roles during the data collection which enabled them to record information accurately from the informants during the interview. Another strength is the data collection tool used (interview guide). It helped the researchers to collect relevant information as it had open ended questions making respondents to express themselves fully. Additionally, all the Norwegian respondents were professionals and they were able to speak English making communication effective.

However, the major weakness of the study was that when it came to information from Zambia, the informants were currently living in Norway for studies. They may not have represented the typical Zambian tradition and culture as they were educated and live in urban areas hence they are influenced by modernity as Giddens (1990), indicates that, modernisation affects our day to day life.

The findings of this project cannot be generalised to the two countries on a broader scale as the sample population was not adequate to represent the study population.

7.0 CONCLUSION

Sexuality is not just sexual intercourse or sexual activity, it is concerned with one's feelings and behaviours. It is an important part of being human, and it has to do with being female or

male. Sex education is key to providing adolescents with the knowledge and skills they need to ensure healthy sexual development in both pre modern and modern societies. Despite Zambia being in pre modernity and Norway being in modernity with different cultures, adolescents pass through similar developmental stages and face similar challenges of life.

The study revealed more similarities as compared to differences. This can be attributed to the fact that both countries Zambia and Norway follow WHO guidelines on adolescents sexual and reproductive health policy.

One of the similarities the study revealed is that, parents from both Zambia and Norway, talk to their children about sex and reproductive health as early as 3 years of age. The role of teachers and nurses in provision of sex education was also similar in that they work in collaboration and nurses in both Zambia and Norway, visit schools once a year to go and give health education in relation to sexual and reproductive health. The school curriculum is also similar since children from both Zambia and Norway start learning about sex education in the fifth grade. They are taught about puberty and reproduction. From 14 to 16 years, they learn about STI, HIV, contraceptives, relationships and types of sex. Motivation of parents talking to their children was another similarity. Almost all the parents got motivated of talking to their children from the questions asked by the children especially after they have learnt from school. Additionally, all the respondents from both Zambia and Norway stated similar benefits of adolescents sex education such as prevention of STIs and unplanned pregnancies. Furthermore, both Zambian and Norwegian informants reported having community health programmes such as Red

Cross in Norway and Nakatendo in Zambia. Challenges faced by both Zambian and Norwegian informants were also similar such as that of the internet.

However, there were also some differences revealed from the study. Parents in Norway tell the truth when a child asks a question regardless of the age, whilst in Zambia parents found it difficult to answer sensitive questions such as where babies come from when the child is still young. Another difference was the organisation of school health programme. In Zambia, guidance and counselling department in schools is managed by a teacher and they do not have school health nurses, whilst in Norway, each school has a school health nurse who has an office within the school.

RECOMMENDATIONS

- ◆ Further research to be done in urban and rural Zambia so as to assess the extent to which technology/modernity has affected the Zambian culture on adolescents sex education.

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APPENDICES

Appendix 1: Permission Letter – Pilot study

Høgskulen i Sogn og Fjordane
6856, Sogndal
Norway

The Head Nurse
Sogndal Health Centre
6856, Sogndal
Norway.

RE: PERMISSION TO CONDUCT A PILOT STUDY IN SOGNDAL

We are students from Zambia on exchange programme and currently studying global knowledge at Sogn og Fjordane university college.

As part of the Examination in global knowledge, we are required to carry out a research project. Our topic is “A comparative study of sex education for adolescents in Zambia and Norway”. We therefore request for your permission to conduct an interview on one nurse from Sogndal health centre in order to test our interview guide. We intend to carry out this

exercise on 11th March, 2014 at your convenient time.

For further details and clarifications, please contact our supervisor Randi Jepsen at the Faculty of Health Studies on telephone number +4799375399, email Randi.Jepsen@hisf.no

We would be grateful if our request was considered favourably.

Yours faithfully,

Caroline M. Wakunuma and Secunda M. M. Kalobwe (Registered Nurses/ Midwives)

Appendix 2: Permission Letter- Main Study

Høgskulen i Sogn og Fjordane
6856, Sogndal
Norway.
11th March, 2014

The Head Nurse
Luster Health Centre
Luster,
Norway.

RE: PERMISSION TO CONDUCT A STUDY AT YOUR HEALTH CENTRE

We are students from Zambia on exchange programme and currently studying global knowledge at Sogn og Fjordane university college.

As part of the Examination in global knowledge, we are required to carry out a research project. Our topic is “A comparative study of sex education for adolescents in Zambia and Norway”. We therefore request for your permission to conduct an interview nurses from your

health centre. We intend to carry out this exercise on any day from 12th to 14th March, 2014 at your convenient time.

For further details and clarifications, please contact our supervisor Randi Jepsen at the Faculty of Health Studies on telephone number +4799375399, email Randi.Jepsen@hisf.no

We would be grateful if our request was considered favourably.

Yours faithfully,

Caroline M. Wakunuma and Secunda M. M. Kalobwe (Registered Nurses/ Midwives)

Appendix 3: Consent Form

CONSENT FORM

I understand that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish. I understand that all the information provided will be confidentially kept. However, this information may be used in presentations in nursing, adolescents sex and reproductive health issues. The study has been explained to me. I have read and understood this consent form and all questions have been clarified. I therefore, agree to participate.

.....

Signature of participant

Date

.....

Signature of investigator

Date

Appendix 4: Interview Guide

INTERVIEW GUIDE

Parents

- 1 Do you talk to your children on sexual and reproductive health issues?
- 2 At what age do you start talking to your children about sex issues?
- 3 How do you communicate with your children on issues patterning to sex and reproductive health?
- 4 What challenges do you face when talking to your children on issues concerning sex and reproductive health?
- 5 How free are you talking to your child of the same sex on sexual matters?
- 6 How free are you to talk to your child of the opposite sex on sexual matters?
- 7 What motivates you to discuss sex issues with your child ?
- 8 Are there any programmes in your community that have been of help in providing sex education to adolescents?
- 9 If yes give example(s).....
- 10

Professionals

- 1 How do you give information to adolescents on sex and reproductive health?
- 2 At what age do you start giving information on sex and reproductive health?
- 3 What are some of the benefits do adolescents obtain in learning about sex and reproductive health?
- 4 What challenges do you face when talking to adolescents on issues concerning sex and reproductive health?
- 5 Are there any programmes at your work place that promote sex education?
- 6 If yes give examples.....
- 7 How adequate is the information in your curriculum on sex education? (For teachers)